CIGNA Claims Services
Rochester Claims Service Center

CIGNA

Permanent Telephone Record

Claimant:	Stephen Alfano	**SSN:**	099-44-9648
Policyholder:	Weill Med College	**Policy #:**	NYK 1972

Date: 12/18/00 **Time:** 10:39 AM

To: ☒ **From:** ☐ Dr. Digiovanni **Cx:** ☐ **ER:** ☐ **MD:** ☒
Other:

Phone Number: 212.434.3432

Spoke With: **Relationship:**

Call Content/Message:
Left message to obtain fax number.

Comments/Action Items:
Callback Required: ☐
Time Zone: Eastern

Signature: [signature]
Case Manager

CIGNA Claims Services
Rochester Claims Service Center

CIGNA

Permanent Telephone Record

Claimant:	Steven Alfano	**SSN:**	099449648
Policyholder:	Weill	**Policy #:**	NYK 1972

Date: 12/15/00 **Time:** 2:10 PM

To: ☒ **From:** ☐ Steven **Cx:** ☒ **ER:** ☐ **MD:** ☐ **Other:**

Phone Number: 718.884.2067

Spoke With: **Relationship:**

Call Content/Message:
Initial Claim Call
Left message with cx's spouse.
Discussed def of dis which is O/O, bwp of 180 days, bsd of 12/3/2000 if approved, and ssdi application and estimation.
Cx said he already has app for ssdi.
Cx had a 50% benefit STD through WEILL, which ended on 12/5.

Cx having pain from his back, and inability to sleep.
Currently on Viox and anti-depressant to help him sleep.
Pt 3x/week.
Cx feels AP has him going to pt to get in better shape to handle sx, as it will be a long sx.
Cx had no questions, and said DQ, auth, and RA to be sent early next week.

Comments/Action Items:
Callback Required: ☐
Time Zone: Eastern

Signature: Adrienne Bailey
Case Manager

CIGNA Claims Services
Rochester Claims Service Center

CIGNA

Permanent Telephone Record

Date 12/14/2000 **Time:** 2:45 pm
To: [x] **From:** [ ] Steven Alfano **Cx** [x] **ER** [ ] **MD** [ ] **Other**
Ph. #: 718.884.2067
Spoke with: **(Relationship)**

Claimant: Steven Alfano **SS#:** 099-44-9648
Policyholder: Weill Medical College **Policy #: NYK 1972**

Call Content / Message:

Initial Claim Call

Left message on answering machine for a call back to discuss claim.

Comments/Action Items:
Callback required [ ] **Ph:** **Zone: EST** [ ] **CST** [ ] **MST** [ ] **PST Other**

Sig: Lisa D'Arpino
Case Manager

Phonedoc.021200

12/14/2000 16:18 FAX 716 231 6502 CIGNA INTEGRATED CLAIM ☑001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1177
CONNECTION TEL	82127443529PP
CONNECTION ID	
ST. TIME	12/14 16:10
USAGE T	08'35
PGS. SENT	4
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.744.3529	December 14, 2000	8:28 AM	

To	From
Name Robert Snow, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.746.2830	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano	NYK 1972
SSN: 099449648	Weill Medical College
DOB: 1/14/58	CIGNA Life Inurance Company of New York

We recently received a Long Term Disability Claim for your patient, Mr. Alfano. In order to assist us with properly assessing his current medical status, could you please complete the enclosed "Physical Ability Assessment" form and forward us the following information:

- Copies of progress notes and test results for the period 4/1/2000 to the present.

I have also sent a signed authorization to release information. Please forward the information within the

Facsimile Transmission Cover Sheet

CIGNA

Transmit to FAX number	Date	Time	Total number of pages (including this sheet):
212.744.3529	December 14, 2000	8:28 AM	4

To	From
Name Robert Snow, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.746.2830	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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- Copies of progress notes and test results for the period 4/1/2000 to the present.

I have also sent a signed authorization to release information. Please forward the information within the next 14 days. I would like to thank you in advance for taking the time to help us obtain this necessary information.

Sincerely,

Shannon Bailey , Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial : 716.231.6502

12/14/2000 10:22 FAX 716 231 6502 CIGNA INTEGRATED CLAIM 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1156
CONNECTION TEL	82128448481PP
CONNECTION ID	
ST. TIME	12/14 10:18
USAGE T	03'58
PGS. SENT	4
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA®

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.844.8481	December 14, 2000	8:28 AM	

To	From
Name Stephen Scelsa, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.844.8490	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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- Copies of progress notes and test results for the period 4/1/2000 to the present.

I have also sent a signed authorization to release information. Please forward the information [illegible]

Facsimile Transmission Cover Sheet

CIGNA®

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.844.8481	December 14, 2000	8:28 AM	

To	From
Name Stephen Scelsa, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.844.8490	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano	NYK 1972
SSN: 099449648	Weill Medical College
DOB: 1/14/58	CIGNA Life Inurance Company of New York

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I have also sent a signed authorization to release information. Please forward the information within the next 14 days. I would like to thank you in advance for taking the time to help us obtain this necessary information.

Sincerely,

Shannon Bailey

Shannon Bailey , Case Manager

CONFIDENTIALITY NOTICE: If you have received this facsimile in error, please immediately notify the sender by telephone at the number above. The documents accompanying this facsimile transmission contain confidential information. This information is intended only for the use of the individual(s) or entity named above. Thank you for your compliance.

[ ] Acknowledgment Requested

To Fax a reply, dial : 716.231.6502

12/14/2000 10:34 FAX 716 231 6502 CIGNA INTEGRATED CLAIM 001

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*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1157
CONNECTION TEL	82122881524PP
CONNECTION ID	
ST. TIME	12/14 10:26
USAGE T	07'45
PGS. SENT	4
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA®

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.288.1524	December 14, 2000	8:28 AM	

To	From
Name Michael Alexiades, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.734.1288	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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I have also sent a signed authorization to release information. Please forward the information within the

12/14/2000 10:55 FAX 716 231 6502 CIGNA INTEGRATED CLAIM 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1160
CONNECTION TEL	82125469288P
CONNECTION ID	
ST. TIME	12/14 10:54
USAGE T	00'43
PGS. SENT	1
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA®

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.546.9288	December 14, 2000	8:28 AM	

To

Name
Sean McCance, MD

Company

Phone
212.546.9285

Address

From

Name
Shannon Bailey

Department
Long Term Disability

Phone
800.532.9288 ext. 6541

Address
255 East Avenue
Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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... information. Please forward the information within the

Facsimile Transmission Cover Sheet

CIGNA®

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212.546.9288	December 14, 2000	8:28 AM	

To	From
Name Sean McCance, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.546.9285	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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- Copies of progress notes and test results for the period 4/1/2000 to the present.

I have also sent a signed authorization to release information. Please forward the information within the next 14 days. I would like to thank you in advance for taking the time to help us obtain this necessary information.

Sincerely,

Shannon Bailey , Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial : 716.231.6502

12/14/2000 11:24 FAX 716 231 6502 CIGNA INTEGRATED CLAIM 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1163
CONNECTION TEL	82127464609PP
CONNECTION ID	
ST. TIME	12/14 11:21
USAGE T	02'46
PGS. SENT	4
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA

Transmit to FAX number	Date	Time	Total number of pages (including this sheet):
212. 746-4609	December 14, 2000	8:28 AM	4

To

Name
Andrew Schiff, MD

Company

Phone
212.746.2879

Address

From

Name
Shannon Bailey

Department
Long Term Disability

Phone
800.532.9288 ext. 6541

Address
255 East Avenue
Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

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- Copies of progress notes and test results for the period 4/1/2000 to the present.

Facsimile Transmission Cover Sheet

CIGNA

Transmit to FAX number	Date	Time	Total number of pages (including this sheet) : 4
212. 746 - 4609	December 14, 2000	8:28 AM	

To	From
Name Andrew Schiff, MD	Name Shannon Bailey
Company	Department Long Term Disability
Phone 212.746.2879	Phone 800.532.9288 ext. 6541
Address	Address 255 East Avenue Rochester, NY 14604

Comments

RE: Stephen Alfano
SSN: 099449648
DOB: 1/14/58

NYK 1972
Weill Medical College
CIGNA Life Inurance Company of New York

We recently received a Long Term Disability Claim for your patient, Mr. Alfano. In order to assist us with properly assessing his current medical status, could you please complete the enclosed "Physical Ability Assessment" form and forward us the following information:

- Copies of progress notes and test results for the period 4/1/2000 to the present.

I have also sent a signed authorization to release information. Please forward the information within the next 14 days. I would like to thank you in advance for taking the time to help us obtain this necessary information.

Sincerely,

Shannon Bailey , Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial : 716.231.6502

Lara D'Ambrosio
Case Manager
Long Term Disability

CIGNA

December 8, 2000

Routing 1760
255 East Ave
Rochester NY 14604
Telephone 800.532.9288 ext 6521
Facsimile 716.258.1780

Steven Alfano
3800 Waldo Ave
Apt 13-G
Bronx, NY 10463

RE: Steven Alfano
S099449648
NYK 1972
Weill Medical College
CIGNA Life Insurance Company of New York

Dear Mr. Alfano;

We received your claim for Long Term Disability (LTD) benefits on 12/072000. You may be entitled to LTD benefits beginning 12/03/2000, however, we are unable to make a decision at this time. To fully understand how your condition prevents you from working, we had to request additional information from your physician(s), Dr. Alexiades, Dr. Digiovanni, Dr. Scelsa, Dr. McCance, Dr. Snow, and Dr. Farmer. We have also requested information from your employer. When we receive this information, we should be able to make a decision on your claim. If we are unable to make the decision within 30 days of the day we received your claim, we will contact you and explain the reason for the delay.

To assist us in managing your claim, we ask that you provide us with:

1. The enclosed Reimbursement Agreement (signed and dated).
2. The enclosed Disability Questionnaire (completed in full).
3. Proof of your age (a copy of your driver's license or birth certificate is acceptable).

We ask that you return these items in the envelope provided by 12/27/2000.

Your LTD benefits are generally reduced by the amount of any other benefits you receive because of your Disability. This includes any Social Security disability or retirement benefits you and your dependents receive, if so stated in your policy. Please notify us immediately if you are receiving or become entitled to receive any income from sources such as:

- Social Security Disability or Retirement
- Statutory Disability*
- Employer Sick Leave
- Veterans Administration
- Worker's Compensation
- No-Fault automobile insurance
- Employer Pension

*If you work in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, you should be eligible for disability benefits under Statutory Disability benefit plans.

If you are eligible for Social Security disability benefits, you should apply for these benefits now. If you are not sure if you would qualify, we can help. One of our Economic Consultants, who are experts on Social Security, may contact you to discuss your case and may ask you to apply for Social Security. If we feel that you would qualify for Social Security benefits, and you choose not to apply for these benefits, your group policy allows us to reduce your Long Term Disability benefit by an amount that we estimate you would be eligible to receive.

We also have Medical Consultants and Occupational Consultants on staff who may be contacting you in the future to discuss other issues that may affect your disability claim. We ask that you extend your full cooperation to these consultants.

If you have other types of coverage that may pay benefits for this condition, you may submit a claim. For example, if your life insurance plan includes a waiver of premium for disability, you may be eligible to submit a waiver claim. Please review the provisions of your employee booklet or certificate.

Mr. Alfano, thank you for your cooperation in completing and returning the requested forms and information. If you have any questions, please call me. I can be reached at our toll free number 1.800.532.9288 extension 6521 from 7:30 a.m. to 3:30 p.m. Eastern Time, Monday through Friday.

Sincerely,

Lara D'Ambrosio
Case Manager

CORNELL
UNIVERSITY

Joan and Sanford I. Weill
Medical College

Department of Human Resources
1300 York Avenue
New York, NY 10021

December 1,2000

Ms. Lara D'Ambrosio
Case Manager
CIGNA
Routing 1760
225 East Ave.
Rochester, New York 14604

RE: LTD Claim for Mr. Steven Alfano

Dear Lara,

Enclosed please find a long term disability claim and attending physician's statement for our employee Mr. Steve Alfano. Mr. Alfano has been continuously disabled by back pain since June 5,2000. He is applying for LTD benefits to begin December 7,2000.

I have also enclosed the following for Dr. Clayson.:

1.. Job description for his duties as a Wage and Salary Manager.
2. Copy of his LTD enrollment Card..

Please process this claim as soon as administratively possible and if you need any additional information please call me at (212) 746-1035.

Sincerely,

Rosemary Cius
Benefits Specialist

NAMES OF ATTENDING PHYSICIANS CONSULTED:

(1) ANDREW N. SCHIFF, MD — 5/00*
505 E 70 ST
NY NY 10021
212-746-2879
*REF'D TO DR. ALEXIADES

(2) MICHAEL M. ALEXIADES, M.D, PC — 6/5/00
159 E. 74 ST.
NY NY 10021
212-734-1288

(3) DR. STEPHEN DIGIOVANNI — 7/5/00
LENOX HILL ANESTHESIOLOGY
100 E 77 ST
NY NY 10021
212-434-3432

(4) STEPHEN SCELSA, MD — 7/20/00
10 UNION SQUARE EAST, SUITE 2Q
NY NY 10003
212-844-8490

(5) SEAN McCANCE, MD — 8/17/00
121 E 61 ST.
NY NY 10021
212-434-4774

OVER →

(6) ROBERT SNOW, MD 8/23/00
523 E 72 ST.
NY NY 10021
212-746-2830

(7) JAMES C. FARMER, MD 8/31/00
523 E 72 ST
NY NY 10021
212-606-1591

13-15-00

JAMES C. FARMER, M.D.
Hospital for Special Surgery
535 E. 70th St.
New York, N.Y. 10021

Alfano, Steven
September 14, 2000

D.O.B.:
MR#:

Mr. Alfano returns today for follow up. He reports that he has performed the physical therapy but has had no improvement whatsoever in his pain and feels that overall the therapy has exacerbated his pain. He does have some intermittent fatigue in the left leg with prolonged walking but notes his primary complaint is his lower back pain. He does feel that at times he has weakness in his tibialis anterior on the left. He denies any bowel or bladder symptoms or night pain.

Physical Examination: Today shows his lumbar spine is non-tender to palpation. He does tend to get significant back pain with forward flexion. His neurologic examination is stable. Neural tension signs are negative.

Impression: Degenerative disk disease of the lumbar spine with some intermittent radicular symptoms on the left probably secondary to L5 nerve root compression noted on the MRI.

Recommendation: At this point, I have reviewed with the patient in detail the nature of the diagnosis of degenerative disk disease and lumbar radiculopathy along with treatment options and risks and benefits. At this point, he reports his back pain is severe and continues to limit him significantly on a daily basis. I do feel it is likely that the pain he is experiencing is from the significant degenerative changes seen at L5-S1. He feels that his pain is severe and continues to limit him on a daily basis and wishes to consider surgical intervention. I have explained to him that I do feel that we would need to obtain a discogram to clearly discern that the L5-S1 disk is the painful level and whether the levels above are normal. After the discogram if it is confirmatory, then I would recommend he have a new MRI as his old one is greater than 3 months old. He is going to have the above performed and will follow up with me afterwards to review it or sooner should he have any questions, problems or concerns.

James C. Farmer, M.D.

JCF/lss

JAMES C. FARMER, M.D.
Hospital for Special Surgery
535 E. 70th St.
New York, N.Y. 10021

Alfano, Steven
August 31, 2000

D.O.B.:
MR#:

Mr. Alfano is a 42 year old male who reports he has had a long history of intermittent low back pain. In April of this year, his back went out and he began to experience pain that was severe. He notes that prior to the episode in April, he felt that his low back pain had overall increased in severity for the last 2 years or so. He has also noted some leg pain involving his posterior thigh and posterior calf. He at times has felt some numbness in his entire foot. Overall, he notes that his leg pain is worse than his low back pain and that the left leg is significantly worse than the right. He reports he has had episodes of occasional urinary retention in the past and saw a urologist who did not recommend any treatment. His bowel function is normal. He notes his pain is made better with rest and is made worse with prolonged sitting, standing and walking. His treatment to date has consisted of Vioxx, Nortriptyline and physical therapy in the past and recent epidural steroid injections which gave him some day relief of pain.

Past Medical History: Significant for borderline hypertension and migraines.

Past Surgical History: Non-contributory.

Medications: Vioxx, Nortriptyline and Norvasc.

Allergies: He has a drug allergy to Codeine.

Family History: Significant for colon cancer in his father and hypertension in his mother.

Social History: He has a 25 pack a year smoking history and does not drink.

Review of Systems: Negative in detail.

Physical Examination: Physical examination today reveals a well developed, well nourished male in no acute distress. He walks with a normal gait. Examination of his lumbar spine does not show any skin abnormalities and there is no tenderness to palpation. He is able to forward flex, bring his fingers to within 6 inches of the floor and extends approximately 30 degrees. He laterally bends bilaterally which is symmetric. Neurologically, motor strength is 5/5 in the lower extremities bilaterally with intact sensation. Deep tendon reflexes are 1+ and symmetric in the lower extremities. His toes are downgoing and there is no clonus. Range of motion of the hips is full and painless. Neural tension signs are negative. Dorsalis pedis pulses are 1+ and symmetric.

JAMES C. FARMER, M.D.

Alfano, Steven
August 31, 2000
Page two

MR#:

MRI: An MRI scan of his lumbar spine was reviewed from June 12, 2000. This shows evidence of severe degenerative changes within the disk at L5-S1. There does appear to be some moderate stenosis at this level.

Impression: Degenerative disk disease at L5-S1 with bilateral lower extremity pain.

Recommendations: At this point, I have reviewed with the patient in detail the nature of the diagnosis of lumbar degenerative disk disease along with treatment options and risks and benefits. At this point, he has not had any significant conservative management with the exception of the epidural. I do feel that he should undergo some physical therapy to see if this will improve his back and lower extremity symptoms. I have asked that he continue to take the anti-inflammatories. I have asked that he follow up with me in approximately 4-6 weeks time to see how he is doing. Should his symptoms still be persistent at that point, then we will discuss the options available to him.

James C. Farmer, M.D.

JCF/lss

12-7-00

Disability Claim

CIGNA Group Insurance
Life • Accident • Disability
Connecticut General Life Insurance Company
Insurance Company of North America
Life Insurance Company of North America
INA Life Insurance Company of North America

GB-608066a (5/99)

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side ***Colorado, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.***

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

The insured is responsible for having this form completed by any/all treating physician(s) without expense to the company. We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED

1. NAME: STEVEN ALEXANDER
ADDRESS: 3800 WALDO AVE Apt 13-G
CITY: BRONX STATE: NY ZIP CODE: 10463
TELEPHONE: 718-884-2067 OCCUPATION: WAGE & SALARY MANAGER

EMPLOYER NAME: CORNELL MEDICAL COLLEGE
SOCIAL SECURITY NUMBER: 099-44-9648
GROUP POLICY NUMBER:
DATE OF BIRTH: 1/14/58

THE REMAINING SECTION IS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1. **DIAGNOSIS (Including any complications)**
(a) Diagnosis (Include ICD-9 or DSM-IV Code)
lumbar degenerative disc disease / lumbar radiculopathy 72252 / 724.4
(b) Subjective symptoms
(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)
(d) Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain
(e) Is illness work related? ☐ Yes ☐ No
(f) If pregnancy please indicate: LMP: EDC: Actual Delivery:

2. **DATES OF TREATMENT** *Month Day Year*
- Date patient first visited you for this accident/illness:
- Date patient first unable to work due to this accident/illness: 6/5/00
- List frequency & date(s) patient was examined for this accident/illness:
- Date of last visit: 11 02 00

3. **NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)**
Hospitalization on: *Month Day Year* THROUGH *Month Day Year*
- Surgery on: *Month Day Year* Type of Surgery:

Name and Address of Hospital
- Medications-type/dosage:
- Medications-type/dosage:

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8 hour day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. Light = 20 lbs. maximum, 10 lbs. frequently
Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. Heavy - 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

II: _____

III: _____

IV: _____

V: Current GAF: _____ Highest GAF in past year: _____

Additional Comments:

6. EXTENT OF DISABILITY

	Patient's Regular Occupation			Any Occupation		
When was patient able to go to work?	*Month*	*Day*	*YearC*	*Month*	*Day*	*YearC*

7. REHABILITATION

(a) Is patient a suitable candidate for further PHYSICAL / PSYCHOLOGICAL rehabilitation services? ☐ Yes ☐ No

If no, explain: _____

(b) Can present job be modified to allow for handling with impairment?

(c) Is patient a suitable candidate for VOCATIONAL rehabilitation services?

If no, when: _____

8. REMARKS

DATE 11/20/00	PRINT NAME (ATTENDING PHYSICIAN) JAMES C. FARMER, M.D	SIGNATURE	DEGREE M.D.
TELEPHONE NUMBER 212-606-1591		PROVIDER TAX ID NUMBER 13-4002812	
STREET ADDRESS 535 E. 70th St.			
CITY OR TOWN NYC		STATE (OR PROVINCE) NY	ZIP CODE 10021

IMPORTANT CLAIM NOTICE

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Group Long Term Disability

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side *Colorado, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.*

Connecticut General Life Insurance Company
Life Insurance Company of North America
Insurance Company of North America
INA Life Insurance Company of New York

CIGNA

TO BE COMPLETED BY THE EMPLOYEE

PLEASE TYPE OR PRINT BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM
USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY

NAME (Last, First, M.I.)		SOCIAL SECURITY NO.	SEX	DATE OF BIRTH
ALFAND	STEVEN A	099-44-9648	☑ M ☐ F	1/14/58

MAILING ADDRESS (Address where you may be reached during the next six months) (Zip Code)	PHONE NUMBER (Includes Area Code)
3800 WALDO AVE APT 13-G, BRONX NY 10463	718-884-2067

NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH	IS SPOUSE EMPLOYED? IF YES,	SPOUSE'S SOCIAL SECURITY NO.
EVA ALFAND	5/23/62	☐ Yes ☑ No ☐ Full Time ☐ Part Time	065-60-9638

Do you have any children under age 18? ☑ Yes ☐ No
Do you have any children age 18-19, who are full-time students in elementary or secondary schools? ☐ Yes ☑ No
Do you have any handicapped children (regardless of age)? ☐ Yes ☑ No
If you answered yes to any of the above questions, please list names and dates of birth.

NAME	DATE OF BIRTH
ANDREA ALFAND	10/1/92
MICHAEL ALFAND	5/18/95

LIST STATES IN WHICH YOU MAY BE LIABLE FOR FILING TAX RETURNS
NEW YORK

DATE OF ACCIDENT OR BEGINNING OF SICKNESS	DATE YOU BECOME TOTALLY DISABLED	DATE YOU PLAN TO RETURN TO WORK
6/5/00	6/5/00	UNDETERMINED

PLEASE DESCRIBE IN YOUR OWN WORDS WHAT IS WRONG WITH YOU (IF ACCIDENT, OR WORK-RELATED, DESCRIBE CIRCUMSTANCES)
PAIN ACROSS LOWER BACK, PAIN & NUMBNESS INTO BUTTOCKS, LEGS, & FEET. UNABLE TO WALK MORE THAN A BLOCK WITHOUT STOPPING, LEFT FOOT DROPS. PAIN IN BACK ~~BUTTOCKS, LEGS & FEET~~

NAMES OF ALL ATTENDING PHYSICIANS CONSULTED FOR THE DISABILITY	COMPLETE ADDRESS AND PHONE NUMBER	DATE FIRST CONSULTED
SEE ATTACHED		

NAMES OF HOSPITALS	COMPLETE ADDRESS	DATE ENTERED-DATE DISCHARGED

Have you applied for Social Security Benefits? ☐ Yes ☑ No

If yes, please attach a copy of your Social Security notice for you and your dependents or a copy of your Social Security denial. If you have not applied, please do so as soon as possible. If you have not received a determination, please attach a copy of your receipt for application.

Are you a Veteran? ☐ Yes ☑ No If yes, have you applied for VA benefits for this disability? ☐ Yes ☐ No
Please attach a copy of your VA Disability Award.

Are you receiving or eligible to receive:	$ Amount/Frequency	Date Began	Date Paid Thru
☐ Yes ☑ No Salary Continuance			
☐ Yes ☑ No State disability Benefits			
☐ Yes ☑ No Group Disability Benefits			
☐ Yes ☑ No Workers' Compensation			
☐ Yes ☑ No Pension Benefits			
☐ Yes ☑ No No-Fault Auto Disability insurance			
☐ Yes ☑ No Any other Disability Income (please identify)			

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.
SIGNATURE OF EMPLOYEE [signature] DATE 10/30/00

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of the authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

SIGNATURE OF EMPLOYEE [signature] DATE 10/30/00

500469b Rev. 5/99

12-7-00

Group Long Term Disability

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
Insurance Company of North America
INA Life Insurance Company of New York
Subsidiaries of CIGNA Corporation

500469b

TO BE COMPLETED BY THE EMPLOYER
PLEASE COMPLETE IN FULL

NAME OF EMPLOYEE (Last, First, M.I.) ALFANO, STEVEN		SOCIAL SECURITY NO. [redacted]	ACCOUNT NUMBER NYK 1972
DATE HIRED 8/5/91	EFFECTIVE DATE OF EMPLOYEE'S LTD COVERAGE WITH CIGNA CO. 9/1/91	WAS EMPLOYEE'S LTD INSURANCE ISSUED ON THE BASIS OF A STATEMENT OF PHYSICAL CONDITION? ☐ Yes ☒ No IF YES, ATTACH COPY	
BASIC EARNINGS 1346.15 (Wk.) Mo.	DATE OF LAST CHANGE IN EARNINGS 7/1/99	LAST DATE(S) WORKED 6/5/00 # Hrs. 7	DATE(S) RETURNED TO WORK N/A

PLEASE CHECK THE APPROPRIATE BLOCKS:
☒ Exempt ☒ Management ☒ Supervisory ☐ Union Local # _____ ☒ Salaried ☒ Full Time ☐ Part Time
☐ Non-Exempt ☐ Non-Management ☐ Non-Supervisory ☐ Non-Union ☐ Hourly Hrs/wk: 35

HAS EMPLOYEE BEEN TERMINATED? ☒ Yes ☐ No	IF YES, DATE 12/6/00	REASON End of Disability	
PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD DISABILITY PREMIUM(see Internal Revenue Code Section 105(a) and Regulations thereunder) 50 %	EMPLOYEE'S CONTRIBUTIONS WERE MADE ON: ☐ Pre-or ☒ Post-tax basis	PREMIUM PAID THRU DATE 12/30/00	
WAS SALARY CONTINUED BEYOND LAST DAY WORKED? ☐ Yes ☒ No	IF YES, WEEKLY AMOUNT $	PAID THRU 12/6/00	
HAS EMPLOYEE RECEIVED SHORT TERM BENEFITS? ☒ Yes ☐ No	IF YES, WEEKLY AMOUNT $ 667.94	FROM 6/5/00	THRU 12/6/00
HAS EMPLOYEE RECEIVED STATE DISABILITY BENEFITS? ☐ Yes ☒ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
HAS EMPLOYEE FILED A WORKERS' COMPENSATION CLAIM? If yes, ☐ approved or ☐ pending? ☐ Yes ☒ No	IF YES, WEEKLY AMOUNT $	FROM	THRU
NAME AND ADDRESS OF WC CARRIER AND WC CLAIM NUMBER			

IS EMPLOYEE ELIGIBLE FOR GROUP REASON ☐ Yes ☒ No	IF YES, MONTHLY AMOUNT $	EMPLOYEE % CONTRIBUTION To Pension _____ %	EFFECTIVE	IS THIS A ☐ DISABILITY PENSION ☐ EARLY RETIREMENT ☐ NORMAL RETIREMENT

LIST ANY OTHER SOURCE OF INCOME TO WHICH THE EMPLOYEE IS ENTITLED AS A RESULT OF THIS DISABILITY

OCCUPATION Wage & Salary Mgr. (ATTACH JOB DESCRIPTION IF AVAILABLE: IF NOT, DESCRIBE JOB DUTIES BELOW)

Was employee's job primarily ☐ sedentary or ☐ did it involve considerable physical activity?

AS CLOSELY AS POSSIBLE, PLEASE ESTIMATE THE PERCENT OF TIME SPENT (TOTAL PERCENTAGE MUST EQUAL 100%):

_____ Sitting	_____ Walking	_____ Stooping	_____ Pushing	_____ Carrying*
_____ Standing	_____ Climbing	_____ Bending	_____ Lifting	

*If job duties require lifting or carrying, indicate average and maximum weights handled. _____

REMARKS

EMPLOYER Weill Medical College	DIVISION	
ADDRESS 1300 York Ave Box 220, NY NY 10021		TELEPHONE NUMBER (212) 746-1085
AUTHORIZED REPRESENTATIVE PRINT: Rosemary Cias SIGNATURE: Rosemary Cias		DATE 12/1/00

ARE BOTH SIDES OF THIS FORM COMPLETED IN FULL?
ATTACH THE ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY AND ANY OTHER DOCUMENTATION.

IMPORTANT CLAIM NOTICE

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Grade: E8

WEILL MEDICAL COLLEGE POSITION DESCRIPTION

Position:	Wage and Salary Manager	FLSA Status:	Exempt
Department:	Human Resources	Division:	
Incumbent:	Steven Alfano	Reports to:	Associate Dean
Edited by:	Patricia Flamm	Date:	March, 1999 (rev)
Reviewed by:	Patricia Flamm	Hours worked:	35

I. POSITION SUMMARY

Under general direction, is responsible for the administration of WMC's non-academic Wage and Salary program, the annual performance appraisal program, and temporary employee administration.

II. POSITION ACTIVITIES

A. Administers the non-academic wage and salary system: audits jobs and prepares job descriptions for promotional evaluation or establishment of formal job description and grade determination; approves and evaluates all exempt and non-exempt positions via the WMC Point-Factor Wage and Salary Systems. Approves all Personnel actions within guidelines involving a change in salary rate. Advises Human Resources Department Head regarding special salary requests and problems; and recommends changes in policy.

B. Handles questions and problems from all levels of faculty, administration and staff regarding wage and salary policy and procedures, holds meetings to discuss as necessary. Advises/counsels administrative staff on various other personnel related matters, refers staff to other authority such as Department Manager or Employee Relations Manager as appropriate. Participates in orientation and training for WMC administrative staff on wage and salary and other general procedural matters.

C. Oversees the processing and posting process of employment requisitions for replacement and new positions. Reviews new positions for content and determines tentative grade and suitability for non-academic posting. Resolves wage and salary problems relating to new positions, new hires, salary increases, and other issues, consults with Department Head as necessary on unusual problems. Works closely with Budget office, Payroll office, WMC Departments and NYPH to resolve problems as they arise.

D. Oversees and supervises the development, updating and maintenance of the Human Resources Department's Web Page (WWW) listing of available positions for internal and external applicants. Oversees weekly production and distribution of paper posting and HR internal Open and Filled Report.

E. Supervises one Sr. Wage and Salary Analyst and one Personnel Clerk: hires, makes recommendations regarding salary adjustments, trains in procedures; assigns work, evaluates performance, assists with questions and problems.

F. Oversees and maintains WMC system of employment of temporary employees; reviews and approves temporary assignments extension requests per established guidelines and policies; approves salary advances for temporary employees in absence of Department Head; resolves problems with hiring departments and/or payroll as necessary.

G. Provides support and back-up coverage to Department Head and Employee Relations Manager as necessary in Employee Relations related matters: assists with investigations and provides input on matters relating to employee grievances and legal cases; officiates Step I grievances as necessary due to scheduling necessities or to ensure objectivity; reviews and approves lay-off requests in absence of the Department Head; may represent WMC in Administrative Hearings such as Unemployment Hearings.

H. Assists in the implementation of new HRS Information System and system modules: serves on User Advisory Committee; attends and participates in implementation meetings; assists in testing, evaluation and debugging activities as necessary.

I. Conducts analysis of non-academic salary range structures on an annual basis: obtains third party salary survey data; may conduct benchmark survey on WMC positions as allowable; and analyzes data via microcomputer. Assimilates and addresses problems and observances in current structures; assists with preparation of various cost estimates; compiles data, graphs and charts and presents findings with salary range adjustment and merit pool recommendations to Department Head.

J. Manages annual non-academic performance appraisal review process: updates and revises exempt and non-exempt performance appraisal instruments; oversees distribution of blank performance appraisal forms to departments and collection of completed forms for incorporation into employee files; advises staff regarding the proper performance appraisal process, including appraisal format and content considerations; brings substandard evaluations to the attention of Employment/Employee Relations Manager.

K. Manages annual employee merit increase program: advises/counsels administrative staff on merit increase guidelines and policies; reviews all annual merit increases for compliance with fiscal year and Human Resources guidelines; ensures completion and submission of employee performance appraisals prior to implementation of merit increases.

L. Provides staff support to Wage and Salary Committee: recommends new Committee members; receives requests for action by committee; collects and prepares data; prepares agenda; presents materials, background information and insight to Committee members; performs follow-up activities. Advises requesting departments on preparation of justification and recommends salary request. Informs departments of Committee decisions.

M. Prepares periodic and special reports concerning analysis of wage and salary matters for Department Head or for use in annual budgeting process, annual affirmative action reporting, and layoff analyses. Uses standard statistical methods in analyzing and preparing data. Utilizes microcomputer for selected programs and special reports.

O. Confers with outside educational, hospital and research institutions to survey for individual positions, wage and salary policy and annual increase information as allowable under Department of Labor and University guidelines. Participates in commercial surveys and completes questionnaires and surveys from Federal Department of Labor and other government agencies and other institutions.

P. Works on special projects as required including design and implementation of revised performance appraisal systems; review and revision of evaluation systems, HR policy and procedure manual, modifications to HRS, development of BDS, installation of computer systems.

Q. Modifies and runs mainframe computer reports via HRS Z-writer report writing system: utilizes system for running of standard and modified reports for use in wage and salary section and other areas of Human Resources and by request; de-bugs and modifies programs as necessary; maintains usage log. Oversees additions and revisions to HRS Job Classification Table. Inputs approved salary ranges into HRS Bracket/Step Table; proofs new fiscal year Table for accuracy.

R. Performs other related duties as required.

III. MINIMUM REQUIREMENTS

College Degree with courses in statistics and minimum of five years of managerial wage and salary experience, with in-depth knowledge of point-factor compensation systems; plus a background including experience in employee relations. Excellent written and oral communication skills, supervisory skills, and knowledge of mainframe payroll/personnel systems and micro computers required.

CHANGE RECORD

Date of Change	Base Salary to $10,000	Empl. Cost	Base Over $10,000	Suppl. Comp.	Empl. Cost	Total Earnings Max. $33,333	Total Empl. Cost
7/93	60,000						
7/98	5,000 (65,000)	6.50					
7/98	5175 (70,000)	6.27					
7/99	5833	7.00					

CHANGE RECORD

Date of Change	Base Salary to $10,000	Empl. Cost	Base Over $10,000	Suppl. Comp.	Empl. Cost	Total Earnings Max. $33,333	Total Empl. Cost
9-1-91	29,167 (36,667)	3.77					
12-1-91	3,000 (38,500)	3.85					
7/92	3208 (39,055) 2305	3.05					
7/93		3.14					

CORNELL UNIVERSITY MEDICAL COLLEGE
GROUP LONG TERM DISABILITY BENEFITS
ENROLLMENT CARD

Name: ALFANO (Last) STEVEN (First) A (M.I.) Sex: ☒ M ☐ F

Date of Birth: 1/14/58 (Month/Day/Year) Date Employed: 8/5/91

Employee's Title or Occupation: WAGE & SALARY MGR Annual Earnings: $35,000 Social Sec. No.: 099-44-9648

☑ I accept the insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

☐ I have been offered LTD coverage and decline to purchase it at this time. I understand that if I wish to participate at a later date, I will be required to furnish evidence of insurability at my own expense and the carrier will have the right to refuse my request.

Signature: X [signature] Date: 9/28/91

LM-35187 (8/89) LIFE INSURANCE COMPANY OF NORTH AMERICA CIGNA